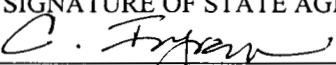



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 04-002	2. STATE NEW MEXICO
<b>FOR: HEALTH CARE FINANCING ADMINISTRATION</b>		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE JUNE 1, 2004	
5. TYPE OF PLAN MATERIAL (Check One):  <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION: 1902 (a)(10)(A)(ii)(XIII) of the ACT	7. FEDERAL BUDGET IMPACT: a. FFY 04      \$ (100,000) b. FFY 05      \$ (375,703)		
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.6-A Pages 12m and 12o	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable): Attachment 2.6- A pages 12m and 12o <i>Supersedes 01-01</i> <i>New Mexico (04-002)</i> <i>Approved: 06/22/04</i> <i>Effective: 06/01/04</i>		
10. SUBJECT OF AMENDMENT:  Payment of Premiums or Other Cost Sharing Charges			
11. GOVERNOR'S REVIEW (Check One): <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED: <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED      State Medicaid Director <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Carolyn Ingram, Director Medical Assistance Division 2025 S. Pacheco Street - ARK P.O. Box 2348 Santa Fe, NM 87504-2348		
13. TYPED NAME: Carolyn Ingram	15. DATE SUBMITTED: <del>April 5, 2004</del> April 20, 2004		
14. TITLE: Director, Medical Assistance Division, HSD			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: 22 APRIL 2004	18. DATE APPROVED: 22 JUNE 2004		
<b>PLAN APPROVED - ONE COPY ATTACHED</b>			
19. EFFECTIVE DATE OF APPROVED MATERIAL: 1 JUNE 2004	20. SIGNATURE OF REGIONAL OFFICIAL: 		
21. TYPED NAME: ANDREW A. FREDRICKSON	22. TITLE: ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID & CHILDREN'S HEALTH		
23. REMARKS:  <div style="text-align: center;"><i>correct</i></div> <i>* Pen + Ink Change made to show Original submission date. (6/4/04)</i> <i>* Pen + Ink Change made in accordance w/ phone call w/ Becky Schwarz (6/15/04)</i>			

STATE <u>NEW MEXICO</u>	A
DATE REC'D <u>4-22-04</u>	
DATE APPV'D <u>6-22-04</u>	
DATE EFF <u>6-1-04</u>	
HCFA 179 <u>04-02</u>	

Revision:

ATTACHMENT 2.6-A  
Page 12m  
OMB No.:

State/Territory: NEW MEXICO

Citation	Condition or Requirement
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1902(a)(10)(A)(ii)(XIII)  
(XV), (XVI), and 1916(g)  
of the Act

Payment of Premiums or Other Cost Sharing Charges

For individuals eligible under the BBA eligibility group described in No. 23 on page 23d of Attachment 2.2-A:

X The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied are described below:

Cost-sharing will be in the form of co-payments to be collected by providers at the time of service as follows:

- \$ 7 per outpatient visit, other practitioner visit, clinic visit, urgent care visit, outpatient therapy session or behavioral health session.
- \$ 7 per dental visit
- \$ 20 per emergency room visit
- \$ 30 per inpatient hospital admission
- \$ 5 per prescription, applies to prescription and nonprescription drug items

The state also has a maximum co-payment amount, after which the recipient will no longer have a co-payment requirement for the remainder of the calendar year. The co-payment maximum amounts are:

\$600. for an individual with income under 100% of the Federal Poverty Income Guideline (FPL), and \$1500. for an individual with income between 100% and 250% of the FPL.

TN No. 04-02  
Supersedes  
TN No. 01-01

Approval Date 6-22-04 Effective Date 6-1-04  
CMS ID:

SUPERSEDES TN 01-01